Methods: A retrospective audit of all colorectal referrals from 30-08-2007 to 31-10-2009 was done. The urgency, type and time to first appointment were analysed. A further detailed analysis was performed in a consecutive sample of 50 patients from each triage group. Type and time to first appointment and number of clinical contacts before diagnosis were compared.
Results: Of the TT group (n = 719), 105(15%) were excluded due to missing data, 203(28%) were triaged as 'urgent', 26(4%) as 'soon' and 385(53%) as 'routine', with mean time to first appointment of 12, 18 and 21 days respectively. In the further analysis of 50 patients, the outcome of TT vs. CT were; mean time to first appointment 17.4 vs. 25.3 days ($p<0.001$) ; mean time to diagnosis 19.5 vs. 34.6 days($p<0.001$), and mean number of clinical contacts before diagnosis 1.18 vs. 1.42($p<0.001$) respectively.
Conclusions: Call centre allotted earlier appointments to those referrals triaged as urgent. The mean time to clinic and time to diagnosis was shorter in the telephone triage group and the number of clinical contacts required was fewer.

SHOULD BREAST SURGEONS PERFORM COSMETIC PROCEDURES? AN OUTCOME EXPERIENCE WITH REDUCTION MAMMOPLASTY

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Aim: Reduction mammoplasty is regarded as a safe procedure with excellent patient satisfaction. There are doubts whether these cosmetic procedures should be carried out only by the plastic surgeons, as they do majority of them, or can breast surgeons provide this service? This study reports the outcome experience of breast surgeons performing reduction mammoplasty.
Methods: Reduction mammoplasties done between Jan 2001-Oct 2009 were included. Data was collected from patient records.
Results: 222 bilateral reduction mammoplasties were performed. Mean age 39.3 (17-66) years and follow-up 2-106 (Median = 56) months. The superomedial pedicle was used in 94.6% (n = 210), and the superior pedicle in 5.4% (n = 12). The mean weight removed from each breast was 640g(120–1300g). There were no complications needing major revision. 58 patients had minor complications (26.1%) and 12 needed minor revision (5.4%). Minor complications included wound infection (n = 16), T-junction breakdown (n = 10), dog-ear (n = 8), hypertrophic/keloid scarring (n = 8), fat necrosis (n = 7), decreased nipple sensation at long-term follow-up (n = 6), asymmetric-nipple (n = 1), inverted-nipple (n = 1) and haematoma (n = 1). Majority of the patients were satisfied with the cosmetic result.
Conclusions: These results show that our outcome is comparable to those in the literature from other plastic surgery units. Therefore, we conclude that breast surgeons can provide cosmetic service similar to our unit.

ROLE OF PRE-OPERATIVE COMPUTED TOMOGRAPHY (CT) SCANS IN PATIENTS WITH SMALL BOWEL OBSTRUCTION (SBO): 2–YEAR SINGLE CENTRE PROSPECTIVE OBSERVATIONAL STUDY

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Aims: Acute SBO is a common surgical emergency. Whilst the commonest cause being adhesions, accurate pre-operative diagnosis optimises patient management. CT is currently the investigative modality of choice. The study aimed to assess if CT can accurately determine the cause of SBO.
Methods: All patients with acute SBO diagnosed by consultant surgeons were included prospectively between November 2006 and 2008. Demographics, timing of CT following admission, CT results and operative findings were tabulated. Fisher's exact two-tailed test and validity were used for statistical analysis.
Results: 91 patients (48M:43F) were identified. Age ranged 23-99, median = 68. 34 cases (37.4%) had CT performed, of which only 1 out-patient CT scan. 19 patients (20.9%) underwent laparotomy, of which 14 patients (73.7%) had a pre-operative CT. Only 41.2% (14 out of 34) of all patients with pre-operative CT underwent laparotomy. 6 out of 14 CT cases correlated with laparotomy findings (sensitivity = 42.9%). The association between CT and laparotomy rates was significant ($p = 0.0004$).
Conclusions: Most patients with acute SBO were managed without CT, which was mostly not required in patients being treated conservatively. CT has a very useful role in the pre-operative diagnosis for the cause of SBO, however, its sensitivity needs to improve in our unit.

EMERGENCY LAPAROTOMY IN THE OVER 80S: IS IT GETTING SAFER?

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Introduction: Emergency surgical admissions in patients aged = 80years have doubled over the past four decades. There is a paucity of outcome data on emergency laparotomy in octogenarians: small studies indicate 30-49% mortality in = 65/ = 75year-olds (most recent published in 1998).Method: We conducted a retrospective case-note review of 92 patients aged = 80 (average 85, range 80-96, 55 females) who underwent 'urgent' or 'emergency' (NCEPOD classifications) laparotomy at a DGH (2006-9). We also contacted survivors' GPs.
Method: We conducted a retrospective case-note review of 92 patients aged = 80 (average 85, range 80-96, 55 females) who underwent 'urgent' or 'emergency' (NCEPOD classifications) laparotomy at a DGH (2006-9). We also contacted survivors' GPs.
Results: Overall in-hospital mortality was 41%. Age was not a good predictor of mortality though female sex carried a worse prognosis (45% vs. 35% in males). Preoperative physiological status (POTTS score) correlated significantly with mortality; $p = 0.0158$. Premorbid physiological status (ASA grade) also correlated with mortality; II:31%, III:44% and IV:50% (n = 26,45 and 16). Three-quarters of patients were admitted to ICU or HDU post-operatively and they experienced higher mortality (45%) than those receiving level-1 care (32%). Survivors mean hospital stay was 22days (range 5-62) and 87% were alive 60days following discharge.
Conclusions: Despite modern, improved peri-operative care, emergency laparotomy in octogenarians is associated with significant mortality and prolonged hospital stay. No single indicator can reliably predict mortality. This information should inform the consent and preoperative decision making process.

RETROSPECTIVE AUDIT OF THE USE OF THE POSTERIOR LIP AUGMENTATION DEVICE (PLAD) FOR RECURRENT HIP DISLOCATION IN PATIENTS WITH PREVIOUS CHARNLEY HIP ARTHROPLASTY

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Introduction: PLAD is a minimally invasive surgical treatment option for patients with recurrent hip instability following total hip arthroplasty (THA). Minimal data exists regarding the long-term outcome after PLAD